



## BILLING AGREEMENT

Saliba's Extended Care Pharmacy services include, but are not limited to, providing prescriptions, maintaining and providing medication administration records, free delivery service, IV services, consultations by our nursing staff and consultant pharmacist and 24-hour emergency service.

Itemized statements are sent out at the beginning of each month for prescriptions sent the previous month. The statements reflect all costs not paid by the insurance including co-pays and the cost of prescriptions not covered by insurance. The balance due is payable directly to Saliba's Extended Care Pharmacy upon receipt but no later than the 25<sup>th</sup> of each month. Any discrepancies shown on the statement must be communicated to the pharmacy within 30 days so we may attempt to resubmit the claim electronically. Depending on the plan, the claim may need to be manually submitted to the plan by the responsible party for reimbursement if the plan will not allow us to submit the claims electronically. Each plan has different limits on how far back it will allow us to bill.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Name of Assisted Living or Skilled Nursing Facility: \_\_\_\_\_

(Required)

### AUTOMATIC PAYMENT

☐ By providing payment information, I authorize Saliba's Extended Care Pharmacy to automatically charge monthly balances to the payment account listed below. (Please check box and complete fields below for autopay)

Payment Account Holder Name (per check/debit/credit card): \_\_\_\_\_

Address statement is mailed to: \_\_\_\_\_

Email: \_\_\_\_\_

☐ Credit/Debit Card#: \_\_\_\_\_ Exp: \_\_\_\_\_ CCV\*: \_\_\_\_\_

-OR-

☐ Bank Name: \_\_\_\_\_ Routing# \_\_\_\_\_ Checking Acct#: \_\_\_\_\_

\*CCV is the last 3 digits of the number on back of card in the signature panel. American Express is the exception with 4 digits on the front of card.

### RESPONSIBLE PARTY INFORMATION

(Required)

**RESPONSIBLE PARTY NAME** (if different from patient) \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**RESPONSIBLE PARTY (signature)** \*\* \_\_\_\_\_ Date: \_\_\_\_\_

By signing this agreement, you agree to receive service from Saliba's Extended Care Pharmacy and guarantee payment for services rendered. If payment is made to you for services rendered by Saliba's Extended Care Pharmacy, you will transfer the payment to Saliba's Extended Care Pharmacy and authorize any applicable pharmacy benefits to be paid directly to Saliba's Extended Care Pharmacy. You also agree to pay any legal fees and court costs incurred in the collection of this account. Signing this agreement also authorizes any third-party payer for the patient to disclose any insurance information to Saliba's Extended Care Pharmacy as well as authorizing Saliba's Extended Care Pharmacy to discuss the patient's care and information with other medical professionals involved in the patient's care in accordance with HIPPA guidelines.

**\*\*Billing Agreement void without signature. Patient or Responsible Party must sign.**

Rev. 3/14/2019